

THE IOWA ALLIANCE OF COMMUNITY MENTAL HEALTH CENTERS

**COMMENTARY ON THE MENTAL HEALTH SYSTEM REDESIGN WORK GROUP
RECOMMENDATIONS OF OCTOBER 31, 2011
INTERIM REPORT #1**

November 15, 2011

ABOUT THIS COMMENTARY

The Iowa Alliance of Community Mental Health Centers (the Alliance), with 19 members, represents over half of such Centers accredited, or deemed to be, by the State of Iowa. Alliance members (*see footnote*) primarily deliver child, adolescent, adult and family mental health services, and often substance abuse treatment, across most of Iowa's 99 counties that include two-thirds of the state's population. These services are paid through Iowa's Medicaid Title XIX program (the Iowa Plan), private insurance, several federally and county-paid programs, and a variety of other nonprofit, for-profit, and private pay funding sources.

SF 525, [commonly referred to as the mental health system redesign legislation and referred to hereafter as Redesign] as passed last session created a number of stakeholder work groups to assist the Iowa Department of Human Services (DHS) in making system redesign recommendations to a legislative interim committee. Redesign also envisions that Community Mental Health Centers (CMHC's) will be indispensable organizations upon which the delivery of these important services will depend. To better prepare CMHCs for this role the legislation also included a substantial re-write of Iowa Code Chapter 230A, the law that regulates the accreditation and operation of CMHC's.

Alliance members were appointed by DHS Director Charles Palmer to serve on six of the seven work groups. In that capacity they recognized there are many options for redesign that the governor, legislature, and various state agencies must consider in reaching the goals enumerated in SF 525.

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Blackhawk Grundy CMHC, Waterloo
Southern Iowa MHC, Ottumwa
Richmond Center, Ames
Vera French MHC, Davenport
Berryhill Center for MH, Ft. Dodge
Midwest Iowa MHC, Iowa City
Plains Area MHC, LeMars
North Iowa MHC, Mason City
Abbe Center, Cedar Rapids
Poweshiek Co. MHC, Grinnell

MH Clinic of Tama County, Toledo
Northeast Iowa Behavioral Health, Decorah
EyerBall CMHC, Des Moines
Center Associates, Marshalltown
Seasons Center for CMHC, Spencer
West Iowa CMHC, Denison
Orchard Place/Child Guidance Center CMHC, Des Moines
Community Health Centers of Southern Iowa, Leon
Waubonsie MHC, Clarinda

Those work group recommendations were released October 31 as a 169 page report to DHS (*referred to hereafter as Interim Report #1*) compiled by the consulting firm Technical Assistance Collaborative (TAC). DHS and TAC are now tasked with melding these into a comprehensive coordinated set of proposals for redesign. This Interim Report #1, and yet-to-be-released preliminary cost projections, will be discussed by the legislative interim committee when it meets November 17.

By early December DHS must also provide that committee with a more detailed analysis of the fiscal requirements for implementing the Redesign plan. Until that fiscal analysis is available the Alliance's response now must necessarily take a broad overview of many policy decisions that the interim committee will be finalizing on December 15. Therefore, the Alliance intends that its commentary on these initial recommendations will be the first of several such documents. We expect public policy makers to continue to assess input from stakeholders while drafting the necessary legislative language.

Our lack of comment now on any specific recommendation should not be taken as either support for or against it. The Alliance supports the vast majority of them but brevity dictates that this commentary focus on two fundamental issues that will be the most difficult to resolve. Likewise, we have chosen neither to recount all of the worthy goals of Redesign nor extensively enumerate all the vexatious problems confronting both the current system and the implementation of a reformed system. Those are well stated and documented in Interim Report #1 and throughout the minutes taken during many hours of work group deliberations. Further background will only be restated if that context is needed to understand the Alliance's commentary.

SUMMARY OF COMMENTARY ON INTERIM REPORT #1

The Alliance commentary cites two challenges facing Redesign, to-wit:

- (1) The transition process "clock" that is compressed by deadlines imposed in part by the federal implementation of the Accountable Care Act, and
- (2) Blending diverse funding streams while simultaneously dividing those finite resources between system cost drivers of eligibility, covered services, administrative expenses, and provider payment levels.

As a response to challenge #1 the Alliance urges public policy makers to:

- ✓ Set realistic timeframes for major transition tasks or give DHS and others flexibility to set that schedule,
- ✓ Provide state agencies adequate funding to staff or contract those tasks, and

- ✓ Make early decisions concerning Iowa's level of participation in the federal ACA as it impacts Redesign.

As a response to challenge #2 the Alliance urges public policy makers to:

- ✓ Structure regional and state level accountabilities so as to blend all public funding sources to alleviate current shortfalls and gaps that each funding system separately faces now, and
- ✓ Set program eligibility and benefit guarantees at levels that leave sufficient resources to provide administrative and provider payment levels to ensure those guarantees can be delivered. The Alliance assumes the legislature and the governor will set the total level of funding for a re-designed system before decisions are made apportioning that funding between each of these cost categories. The Alliance explains in some detail the interdependence of each of these.

THE FUNDAMENTAL CHALLENGES

The Alliance supports the fundamental Redesign vision in SF 525 and Interim Report #1. The two greatest challenges its implementation faces is the need to (1) use wisely the less than 24 months available to transition from the current system to just the basic elements of Redesign and (2) achieve a delicate balance in apportioning multiple funding streams between the cost driver elements of the redesigned system as a whole. Interim Report #1 recommendations address some but not all of these concerns. We look to the interim committee, with the guidance of state agencies and the continued involvement of the work groups and citizen input, to do so.

I. THE "TIME FOR TRANSITION" CHALLENGE

Iowa faces a "time for transition" dilemma. On the one hand, time is needed to achieve a smooth transition from the old to new system. A deliberate Redesign transition process requires meshing scores of programmatic and systemic structural pieces involving thousands of patients, providers, regulators, governance bodies, and other stakeholders. Taking time also allows for policy making adjustments in the original Redesign to meet unexpected challenges, avoid unintended consequences, allow funding streams such as county property tax levies to be authorized and collected, and most importantly to avoid doing harm to patients who already depend on the system. For example, the Alliance has made several suggestions during the regional work group sessions concerning implementation timelines for creating regions. DHS will be directed by the legislature to drive the transition process calendar and be held accountable for meeting it. To do so DHS and allied agencies must have adequate resources, both in-house and under contract, to do this critical job. For example, vetting and approving proposed or imposed regions will likely be very resource intensive.

We recognize many feel a compelling urgency for an aggressive implementation schedule because of deadlines imposed on the state in the federal Accountable Care Act (ACA) and to achieve systemic savings and/or re-direct savings into needed areas of improvement. Failure to meet those deadlines can jeopardize major federal funding for some parts of Redesign elements and related programs such as Medicaid. Complicating that calendar is the uncertainty concerning the legal fate of the ACA in federal court, and the uncertainty of Iowa's own level of participation within the ACA framework. The Interim Report #1 and stakeholder discussions have rightly assumed for planning purposes that the current ACA deadlines will hold.

II. THE FISCAL CHALLENGE – ACHIEVING A CREATIVE BALANCE

Experience tells us that governmental restructuring is almost always designed around a more or less pre-determined total amount of public resources that will be devoted to the final product and not the other way around. We make the same assumption.

The Alliance believes there are two major fiscal challenges to overcome if Redesign is to be successfully implemented:

1. The regional concept must successfully blend together the currently two chief public funding systems (State/Medicaid Iowa Plan and the County/property tax) to alleviate shortfalls and gaps that each funding system separately now faces, and
2. The regional concept must operate in an environment that achieves a sustainable balance between the major categories of cost drivers for the system including (1) who is eligible for services, (2) what health care benefits must be provided such as mandated core services, (3) what administrative costs will be allowed, and (4) which health care providers will be paid for services and how much.

As to **Fiscal Concern #1** the Alliance recognizes that SF 525 directed that fiscal issues be addressed primarily by the legislative interim study committee. That committee met in October to gather background on funding options but made no decisions so at this point it is very unclear how the proposed regional system will address this #1 concern. There are a number of people who continue to believe that the regional approach is merely a local government political solution to a \$125 million state funding problem and that it is drawing needed energy away from other pressing issues such as workforce shortages and the goal of uniformity for core services across the state. They assert with some justification that this Redesign process should not go to elaborate lengths to create a regional system unless there is a probability that it won't create more problems than it actually solves. We will be looking to the November 17th meeting of the interim committee to allay that concern.

Fiscal Concern #2 involves the Alliance's belief that failure to achieve a balance in funding four key categories of cost, whatever level of total funding is eventually available, could cripple Redesign no matter how well it is otherwise conceived on paper. There are advocates with

goals for configuring one or two of these categories to their liking but legislative decision making must achieve a balance in funding so all four are complementary.

Eligibility – The Alliance supports the recommended goal for income eligibility of 200% of federal poverty level (FPL) for mental health services but agrees that for now the cost implications described below makes it more prudent to begin with 150%. That decision result in serving fewer people but the “savings” achieved by serving fewer people may result in the capacity to provide a better array of core services to those who are served, resulting in the longer term longer term in less cost to the system and therefore to taxpayers. Parallel arguments can be made if those eligibility “savings” are spread to needed administrative services or higher provider reimbursement rates to gain increased access to more effective professional services.

Workgroup recommendations include potentially expanding eligibility criteria for services based on diagnosis and/or functional assessment measures (example, Autism Spectrum Disorders). While these recommendations have merit, these criteria changes will likely increase the number of individuals eligible for services which undoubtedly relates to increased costs to the system.

Benefits/Core Services – The Alliance assisted in the re-drafting of Chapter 230A so public policy makers would know what to expect in core services from an accredited CMHC. That drafting was incorporated into SF 525 and is now law. What is missing in the recommendations to date is a clear mandate establishing CMHC’s as the safety net provider in each region for providing those core services. All of the recommendations now before DHS and the interim committee need to be examined to ensure they are consistent with the key role envisioned for CMHC’s in SF 525.

Good ideas were suggested for significantly expanding the list of mandated core and supplementary services and some are included in work group recommendations. That list, if approved, would make the list inconsistent with those adopted in SF 525. The Alliance asks that policymakers be cautious about expanding this CMHC list, and lists applicable to other health care service providers, without considering the fiscal impact on the other three categories of systemic costs noted here.

Administrative Services – This is a cost category that may be the most worrisome to Alliance members. It appears to us to be the least well understood of any cost category. Specifically, the Alliance doubts a convincing case can be made that all regions can be operated on an administrative services budget of less than 5% of expenditures as currently required by SF 525. [See Sec. 1.4(j)(12)(e)] The Alliance is also unconvinced by the proposition that much of that administrative cost will be a virtual zero sum game whereby currently county funded administrative services and resources will be simply transferred to a regional entity to offset the latter’s costs. The Iowa models suggested in the Regionalization work group did not include a thorough scrutiny of just what

constitutes an “administrative cost.” Without such analysis policy makers should not use that assumption in setting a statutory ceiling on those costs. History instructs that any administrative cost overruns are likely to be passed on, not by narrowing program eligibility criteria or cutting program benefits, but by reducing provider reimbursement levels.

Absent a complete fiscal analysis, the Alliance has concluded that empowering five to 15 regions with broad discretion for creating administrative infrastructure will generate so much transactional friction as to cause the regional concept to become unjustifiable and thereby fiscally unsustainable.

We urge interim committee legislators to place a major burden of proof on those suggesting that financing regional administrative services is virtually a zero sum game and to give close scrutiny to estimates of these costs. We think they may conclude that fiscal prudence dictates building a firewall around this possibility and instead require that many of those functions be centrally administered and the costs spread fairly between those regions needing a particular level of administrative services.

Perhaps the most obvious area of common need for uniformity is development and deployment of a centrally administered information technology structure for data collection and analysis. The state could do so by entering into a master contract with one or more competitively selected vendors from which a region could purchase the services it needs. DHS IME has undoubtedly learned a great deal from its 16 years of experience under the Iowa Plan. Again, documented savings could be devoted to funding public policy objectives in the other cost categories or applied to reducing the overall cost of the Redesign system.

Building an Effective Provider Network – Core, ancillary, and supplementary goods, services, and facilities are phantom benefits from a client perspective if there are too few health care providers credentialed to deliver needed treatment services or who are not available electronically or geographically to best serve that client’s needs. A benefit without access to a provider is no benefit at all. Again, from a fiscal perspective this is a function of adequate reimbursement to attract that manpower and investment commensurate with provider training. This needs to be coupled with expanding scope of practice parameters for some health care providers consistent with (1) ensuring patient safety, (2) maintaining effective treatment modalities, and (3) expanding timely availability of such providers as uniformly across the state as possible.

Many excellent work group recommendations have addressed this workforce shortage, and the Interim Report #1 includes a recommendation for formation of a standing Workforce Development group. Still, the Alliance urges that the health care provider shortage is such a serious problem and a major key to the success of Redesign that immediate and bold steps must be taken now. One such step that will require strong leadership from legislators is foster a climate of “or else” compromise among competing

health care providers on scope of practice issues where it appears to be a turf battle rather than interest in protecting public health.

There is one issue in particular that seems to not have been directly addressed by any work group. That is the concept of mandating that any willing provider be entitled to join any given network of similar providers organized by an entity for the purposes of cost and quality control of service delivery. The Alliance will be very concerned if the current discussion around “any willing provider” of core safety net services continues as the effective funding needs of most safety-net services is incongruent with the “any willing provider” model. As envisioned in SF525, CMHC’s role in their communities is much like the local fire department and law enforcement where “any willing provider” is not an effective approach to ensuring needed services are available when needed. In the private sector the concept of preferred provider networks has historically been an extremely effective tool, one used extensively by health insurance companies to control cost, ensure availability, and enhance the quality of health care services. We urge the interim committee to have an open and collegial discussion of /the “any willing provider” issue at its November 17th meeting.

Alliance members are health care providers and we recognize the importance of leading this discussion by example. That is why a number of our members are initiating discussions between community mental health centers, federally qualified health centers, and other health care providers to find areas of collaboration through a variety of contractual arrangements and even merger of facilities and mission.

We intend to be leaders in providing each region with the full range of core and other services needed to serve our respective populations because we believe this will lead to creating health care homes for our patients, a major goal of Redesign. There are many tools available including financial and performance based incentives that the interim committee can build into its legislative package. These include, for example, provider reimbursement levels, flexible facility licensing requirements to meet local or regional needs, scope of practice changes, and many more.

III. LOOKING FORWARD

These then are the major criteria by which the Alliance will judge and advocate for or against specific statutory language and related legislative and state executive branch policy making. The need for bi-partisanship and compromise on the means is essential. Neither requires anyone to give up principles or to abandon the well conceived goals of this enterprise. The reader can be assured of the Iowa Alliance's continuing commitment to the Redesign process.

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